| Category | Question | Answer |
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| Residential Services | Does "present" in .1704 mean the staff need to actually be there, or simply on duty? | "Present" means that staff have to be in the facility according to the numbers specified in .1704. Emergencies must be documented, and must not be reflective of an ongoing pattern of non-compliance with staff requirements. |
| Residential Services | What do I do if all three of our clients have three different appointments at the same time? Do I have to send two employees with each client? | Not necessarily. If each of these clients is assessed as being capable of functioning in the community with just one staff person, then this should be documented in their treatment plan accordingly. |
| Residential Services | Can a QP perform the functions of an AP in residential setting ? | The QP is qualified to perform AP functions, but cannot do both at same time. |
| Residential Services | Can one person be a "Q" and a Licensed Professional? | The licensed professional can also be a Q, but not necessarily vice versa, and cannot perform the functions of both the LP and the Q at the same time. |
| Residential Services | Can one person be a "Q", an AP, and an LP? | The requirements for each provider are clear in state statute. The higher level staff may perform the functions of the lower level staff, but not the other way around. |
| Residential Services | Is there a list of licenses for LPs that specifies which ones are acceptable? | Refer to Medicaid's Bulletin for Direct Enrollment for list of all the licensed providers. www.dhhs.state.us/dma/bh/8c.pdf |
| Residential Services | .1705(a) states that a Licensed Professional must provide face to face clinical consultation in each facility. We don't have a room that is appropriate for individual therapy in our group home. Can the LP bring the child to another group home or an office in order to conduct therapy in a more appropriate environment? If we have to have therapy in the group home, we're going to have to put two kids in a room together (sex offenders potentially) in order to dedicate a room for the LP. My LME says it's okay to take the kids off site. What do I do? | There is no requirement that a dedicated space be provided in the facility for therapy to occur. It is expected the provider will use good judgement in providing an alternative that is safe and confidential in which therapy can take place. |

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| Residential Services | Can overnight non-awake staff sleep on a couch in the living room? | No. Staff must have separate sleeping quarters that clients do not have access to. |
| Residential Services | Per Implementation Update #11 (Child Residential Rules and Definitions): Please clarify why this memo says the required four hours of treatment may be provided by a QP or an AP when the service definitions clearly indicate that consultative and treatment time must be provided by a QP. Has DMH changed the Level III definitions? If so, where can I find the most recent version? [linnea.petty@youthopp.org] | In Update #11 it was indicated the required four hours of treatment for each individual child could be provided by an AP or QP. While this is correct in the rules, it is clear in the Service Definition that the requirement can be met only by the QP (or higher) providing the individual treatment. In an instance in which the rules and Service Definition address an issue differently, the most restrictive guidance should be followed. We are sorry for the confusion. |
| Residential Services | The Executive Order states that the new residential rules have an effective date of permanent rule no earlier than July 1, 2006 on page 2 as it relates to G.S.150B-1 General Provisions (Rule Making Process) but on the same page (2) it states that permanent rule regarding residential treatment for children ( .1301, .1700, .1701 - .1708 is made effective April 3, 2006 pursuant to G.S. 150B - 21.3 (Change in federal or state budgetary policy)? Simply put do providers comply with rules on April 3rd or July 1st? If April 3rd, meeting the staffing requirements and client to staff ratios as set forth in .1701 - .1708 with out new rate approvals will be an issue. Shouldn't there be a transitional plan for child residential providers to comply with the new rule? | The transition expectations concerning the changes in the residential treatment rules 10A NCAC 27G .1301 and .1701 - .1708 are specified in two Memorandums addressed to Providers Licensed for 10A NCAC 27G .1300 from Stephanie Alexander, Chief, MH Licensure and Certification Section, DFS dated April 1, 2006 and May 30, 2006. The memorandums may be accessed from the Division for MH/DD/SAS website: http://www.dhhs.state.nc.us/mhddsas/. The new rates for residential treatment Level III and Level IV became effective on April 3, 2006. |
| Residential Services | The [.1301]rule states this applies to residential treatment Level II, program type. Does this apply to family type too? Remember we have dual licensed facilities providing Level II treatment 122C facilities and 131D facilities. | No, facilities providing residential treatment Level II, family type service are licensed in accordance with Division of Social Services therapeutic foster care rule requirements. This change in licensure became effective in 2002. The service definition has not changed. It is still considered Level II, Family type until the new service definition is approved. |

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| Residential Services | In section C [of Rule .1301] SA is not included as it states adolescents who have a primary diagnosis of mental health or emotional disturbance and who may also have other disabilities. In .1700 and .1900 it specifies all three disabilities MH/DD/SA. Shouldn't it be consistent? | The amendment to Rule .1301 is intended to provide a licensure category for existing facilities providing residential treatment Level II, program type service. It is not anticipated that there will be significant growth in this service. For this reason only the most basic changes were made to this Section of rules. |
| Residential Services | In section D [of Rule .1301] it states may receive services in a day treatment facility. I thought licensed Level II group homes could not receive day treatment as a service exclusion per the service definition? | That is correct. The rules were formulated prior to the service definitions being approved by CMS. Medicaid billable day treatment may not be provided during the same authorization period as residential treatment. |
| Residential Services | Does .1300 [.1301] imply under section F that the facility would be keeper of the plan? This would be a problem as most Level II programs given the way they are licensed 122C or 131D don't have QPs | No, the amendment to Paragraph (f) is a restatement of the requirement that has been in effect since the rule was adopted in 1996. There is no intent to make the facility the keeper of the plan. The amendment was written to comply with a request by the Rules Review Commission for a technical correction. |
| Residential Services | Under section B of .1701 it specifies staff are required to be awake during client sleep hours. If providers are to meet this requirement, when will new rates be approved to fund this requirement? | The new rates became effective on 04/03/2006. |
| Residential Services | Under section A of .1702 each facility has to have a QP. Can that QP be contracted or does rule require an FTE? | The rule does not prohibit contracting for staff for the period of time required by the Rule. |

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| Residential Services | Under section D of .1702 it states the QP will coordinate each child's treatment plan and provide CM functions. Is the residential rate all inclusive or can a provider bill for Community Support-Child and Residential III separately if Endorsed? Is same provider providing these two functions not a conflict of interest? | The clinical and administrative responsibilities of the qualified professional are considered part of the residential treatment service and included in the rate. If the provider is endorsed for both Residential Level III and Community Support - Child services, it can only bill for both services that are provided at the same time when they have been performed by separate staff of each service. The same staff persons cannot perform Residential and Community Support services simultaneously. Please review the service exclusions/limitations contained in the Community Support service definition at http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servdef3-27-06rev.pdf. |
| Residential Services | Under .1705 it states that four hours of consultation per week by a licensed professional shall be provided. Is that included in the residential rate? It later states under section B of .1705, that the licensed professional or provisional professional can provide individual, group or family therapy. Is this an all inclusive rate or could the licensed practitioner bill this separate? Would the provisionally licensed therapist be authorized by the LME and billed through the LME? | Yes, the licensed professional's face to face clinical consultation is included as a part of the residential treatment service and was accounted for in the development of the Medicaid reimbursement rate. Paragraph (b) of the Rule specifies the activities that constitute the face to face clinical consultation required in Paragraph (a) of the Rule. These activities are not billed separately. |
| Residential Services | I have in deed reviewed the memorandum dated July 10th 2006.Concerning 4 hours of C&T services by a LP. My question is this : I have an LP in the programs for 4 hours per week in a group setting. Should there be a QP performing 4 hours in addition to the LP's 4 hours? I'm understanding the rules to mean that the requirements may also be met by treatment in a group setting by a QP. Am I in compliance? | The four hours of LP time may be counted as the treatment time in the context you describe. The use of a LP for treatment meets the intent of four hours of individual/group treatment per consumer as well as the four hours of available LP time in the facility. |
| Residential Services | Under .1706 it states under section C that day treatment would be coordinated, under the new day treatment service definition this is an exclusion. | That is correct. The rules were formulated prior to the service definitions being approved by CMS. Medicaid billable day treatment may not be provided during the same authorization period as residential treatment. |

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| Residential Services | Also, under section C of .1706 it states that the Residential facility will coordinate with the school for education services. Doesn't this go against the Out of Community Placement Process (SB163) that a CM or CSC QP would need to facilitate? | No, Paragraph (f) is not intended to supersede case management or Community Support responsibilities. It is a statement requiring the residential treatment facility to work in concert with the local education agency or other agencies involved in other aspects of the client's care and treatment. ) |
| Residential Services | In addition have new therapeutic leave rates or room and board rates been established to reflect new draft residential rates? | No. It is currently being reviewed. |
| Residential Services | Under .1708 it states a facility would need to give written notice on an transfer to discharge from the facility. : What is this process? Is there a standardized form? | The rule requires the residential treatment facility to provide advance written notice of transfer or discharge to the treatment team including the legally responsible person. It would be expected the Community Support worker would be contated and included during the decision process There is no standardized notification form. |
| Residential Services | New .1900 Rules - The state has typically accredited these facilities and DMA has allowed these facilities to direct enroll, with the LME need to Endorse these facilities in the fourth phase of Endorsement? (June - August)? | PRTF facilities are excluded from the endorsement process. |

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| Residential Services | There appears to be an difference between the Service Definition and the Medicaid Special Bulletin (May 2006) regarding service limitations. The Service Definition on the DMH/DD/SAS web site indicates that the Community Support provider can bill for time spent "providing coordination during the provision of [residential] service." The service definition allows for billing a maximum of 8 units/month to provide coordination with the residential provider. But there was no corresponding limitation in the Medicaid Bulletin. An LME has reportly told providers said that if they bill for Community Support, specifically, coordination activities while a child/youth is in residential, the residential service provider will be denied payment for the residential services provided. The provider doesn't want to mess up a residential provider's billing, but wants to get paid for the Community Support provided. Can you clarify? [edaye@behaviorallink.com] | Community Support can be provided when child is in residential for 2 hours a month for the case management component and that should not affect the residential provider's billing. The residential provider will not be billing for Community Support. See question #31. |
| Residential Services | .1702- (d) (5)- Who is responsible for the PCP while a consumer is in a residential setting ? | The PCP will continue to be monitored and updated by the Community Support provider during the residential stay. The goals and strategies developed in the residential setting will reflect the goals of the PCP. |